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# The sustainability of midwifery group practice: A cross-sectional study of midwives and managers

Leonie Hewitt [a,*], Ann Dadich [b], Donna L. Hartz [a], Hannah G. Dahlen [a]

[a] School of Nursing and Midwifery, Western Sydney University, Locked Bag 1797, Penrith, NSW 2751, Australia
[b] School of Business, Western Sydney University, Locked Bag 1797, Penrith, NSW 2751, Australia

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ABSTRACT

*Problem:* Although there is robust evidence for the benefits of midwifery group practice (MGP) caseload care, there are limited opportunities for women to access this model in Australia. There is also limited knowledge on how to sustain these services.
*Background:* MGP can benefit childbearing women and babies and improve satisfaction for women and midwives. However, sustainability of the model is challenging. While MGPs are often supported and celebrated, in Australia some services have closed, while others struggle to adequately staff MGPs.
*Aim:* To investigate midwives and managers opinions on the management, culture, and sustainability of MGP.
*Methods:* A national survey of MGP midwives and managers was distributed (2021 and 2022). Quantitative data were analysed using descriptive statistics, and qualitative data were analysed using content analysis.
*Results:* A total of 579 midwives and 90 managers completed the survey. The findings suggest that many MGPs do not support new graduates and students to work in MGP. Over half (59.8%) the participants (midwives and managers) reported that the women and families were the best aspect about working in MGP, while 44.3% said the effects on midwives' lifestyle and families were the worst aspect.
*Discussion:* The relationship with women remains the major motivator for providing MGP care. However, work-life imbalance is a deterrent, exacerbated by staffing shortages. Staffing might be improved by adequate renumeration, strengthening orientation, and attracting new graduates and students through experience in MGP.
*Conclusions:* There is a need to attract midwives to MGP and improve work-life balance and sustainability.

**Statement of significance**

**Problem or issue**

Sustaining MGP continues to be problematic, even though there are clear benefits to women, babies, and midwives.

**What is already known**

Although many MGP services are implemented with great enthusiasm, many face sustainability issues in the long-term.

**What this paper adds**

There is a need to improve staffing and ensure the readiness of new graduates and students through access to experience working in MGP. Appropriate renumeration and work-life balance might also aid sustainability.

## Introduction

### *Background*

Although evidence shows comparable or improved outcomes for both mothers and babies who receive midwifery-led continuity of care [1], few childbearing women can access this model of care [2]. These outcomes include fewer intrapartum interventions (epidural, episiotomy, and operative vaginal birth); increased spontaneous vaginal birth; maternal satisfaction; fetal and neonatal benefits [1], in particular for First Nations babies [3]. There are also benefits for midwives who work in these models, including more satisfaction and less burnout [4, 5].

In Australia there are several ways that midwives provide midwifery-led continuity of care. One way is through private midwives (self-employed) who offer continuity of midwife-led carer; another is team

* Corresponding author.
*E-mail address:* leonie.hewitt@outlook.com (L. Hewitt).

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midwifery, where a team of employed midwives work shifts to promote a philosophy of continuity of care to a group of women, rather than continuity of carer [2]. Midwifery group practice, (MGP) caseload care is where midwives (usually employed) work in a group to cover each other for time off call, and provide continuity of carer to a caseload of women [6]. Each woman has a -known primary midwife, who works on-call and is paid an annualised salary. In Australia, MGP is the most common midwifery continuity model of care [2].

Despite widespread support for midwifery-led continuity of care [7–10], Australia has been slow to offer these services [2,11]. This might be due to difficulties in implementing and sustaining MGP [12–14]. These difficulties were exacerbated during the COVID-19 pandemic, where many MGP services were disrupted. Many MGPs were cut back and some closed, requiring midwives to work elsewhere, at a time when women were isolated and needed relational care the most [15].

Sustainable MGPs are cost effective, adequately staffed, and supported by all stakeholders [16,17]. Caring for the midwives requires a model that engages and supports them, ensures they can develop relationships with women across the maternity continuum and have autonomy in how they practise [17,18]. This study established the conditions that help to optimise the management of MGP in Australia. It presents the quantitative and qualitative findings from a national survey in Australia investigating midwives and managers opinions on the management, culture, and sustainability of MGP models.

## Methods

### *Study design and data collection*

The questionnaire is a component of a larger sequential mixed methods study that explored what determines optimal management of midwifery group practice in Australia. The questionnaire was designed using the qualitative findings from interviews and a focus group with MGP midwives, managers, and clinical midwife consultants [19]. The purpose was to determine MGP midwives' and managers' views across seven key areas. This study reports findings pertaining to staff orientation (students, new graduates, and new experienced midwives), culture, management, sustainability, and consumers. Participant demographic details are presented in Table 1 and are discussed in previous papers [19].

MGP midwives, managers, and clinical midwife consultants were invited to pilot-test the questionnaire and consequently six midwives and managers offered feedback to refine the questionnaire. Participants were invited to complete the questionnaire via social media and advertisements posted in communication from the Australian College of Midwives and Women's Health Care Australasia member emails. The questionnaire was designed using the online platform, Qualtrics [20]. Questionnaire data were collected from March 30, 2021 to July 22, 2022. Due to the COVID-19 pandemic, data collection was extended to accommodate disruption experienced by some MGP services. Of 790 responses, 669 participants met the inclusion criteria, whereby they were employed within the last five years as a MGP midwife, manager, or executive manager of an MGP service, and had completed the demographic and workplace items. Once they commenced the survey, they were asked to self-identify which position they held and were taken to the end of the survey if they chose 'none of the above'.

### *Quantitative data analysis*

Survey data were cleaned to remove data that had not met the inclusion criteria. Descriptive statistics using the IBM SPSS software platform [21] calculated frequencies and percentages. Likert question data were analysed using 'split file' to analyse managers and midwives separately in SPSS [22]. In the demographics table, missing data are identified, and percentages calculated accordingly. In the rest of the survey data when the denominators have changed due to missing data, the percentages are corrected accordingly, as performed in previous research [23].

**Table 1**
Participant demographic details.

| Position | | Participants | Percentage |
|---|---|---|---|
| | MGP midwife | 579 | 86.5 |
| | MGP manager | 68 | 10.2 |
| | Senior manager of an MGP service | 22 | 3.2 |
| **Indigenous status** | | | |
| | Yes, Aboriginal and/or Torres Strait Islander | 8 | 1.2 |
| | Rather not say | 3 | 0.4 |
| **Ethnicity** | | | |
| | Australia | 525 | 78.5 |
| | Europe | 92 | 13.7 |
| | New Zealand and Pacific Islands | 29 | 4.3 |
| | North, South and Central America | 14 | 2.0 |
| | Africa and Middle East | 2 | 0.29 |
| | North, South and Central Asia | 7 | 1.0 |
| **States and Territories working** | | | |
| | New South Wales | 216 | 32.3 |
| | Queensland | 192 | 28.7 |
| | Victoria | 84 | 12.6 |
| | South Australia | 59 | 8.8 |
| | Western Australia | 64 | 9.6 |
| | Tasmania | 16 | 2.4 |
| | Northern Territory | 20 | 3.0 |
| | Australian Capital Territory | 18 | 2.7 |
| **Age range (years)** | | | |
| | 21–29 | 128 | 19.1 |
| | 30–39 | 171 | 25.6 |
| | 40–49 | 163 | 24.4 |
| | 50 and over | 207 | 31.0 |
| **Years practising midwifery** | | | |
| | 0–9 | 340 | 50.9 |
| | 10–19 | 152 | 22.8 |
| | 20–29 | 93 | 13.9 |
| | 30 or more | 82 | 12.3 |
| | Not a midwife | 2 | 0.3 |
| **Midwifery qualification** | | | |
| | Bachelor of midwifery | 297 | 44.4 |
| | Graduate diploma in midwifery | 176 | 26.3 |
| | Double nursing/midwifery degree | 66 | 9.9 |
| | Hospital certificate in midwifery | 94 | 14.1 |
| | Other | 32 | 4.8 |
| | Not a midwife | 2 | 0.3 |
| | Missing | 2 | 0.3 |
| **Highest level of education** | | **Participants (*n*=637)** | **Percentage** |
| | Hospital certificate | 27 | 4.2 |
| | Qualification from Technical and Further Education or diploma | 7 | 1.0 |
| | Undergraduate university degree | 271 | 42.5 |
| | Postgraduate diploma | 169 | 26.5 |
| | Postgraduate Masters' degree | 153 | 24.0 |
| | Doctorate | 5 | 0.8 |
| | Missing | 5 | 0.8 |

### *Qualitative data analysis*

Content analysis was undertaken using NVivo [24] for the text responses to the open-ended questions. NVivo is a software tool that enables researchers to code the data into categories that are easy to visualise, organise, and store. Most open-ended responses covered more than one category – thus, items of coding were generally more than the number of participants.

Content analysis was used to quantify similarities within the text [25]. Because it serves to quantify meaning it is often referred to as a blending of qualitative and quantitative methods [26]. Content analysis was performed using a conventional approach in a sequence described by Hsieh and Shannon [27]. The sequence involved: (re)reading the data for familiarity and identifying keywords or phrases to code the data. Codes were organised, while adding, or changing some that did not fit.

This was an iterative process that meant (re)checking the data and splitting or combining the codes until they were organised into appropriate (sub)categories. These were then discussed and critiqued within the team.

### *Ethics*

Ethics approval was obtained through Western Sydney University Human Research Ethics Committee, Approval Number H13428. All participants were offered detailed information on the study via a hyperlink and asked whether they consented to participate in the survey. A 'no' response took them to the end of the survey. All responses were anonymous and any open-ended responses that divulged information that might identify the individual or service was changed. Because the responses are anonymous, responses could not be withdrawn after submission and participants were made aware of this.

### *Researcher position*

Three of the researchers have experience working in, leading, and researching midwifery models of care. This gave them an insider's perspective on the subject matter and thus required many hours of reflection to ensure objectivity (as much as possible). The fourth researcher is not a midwife but has experience in healthcare research, including models of midwifery care. This provided objectivity and a reflexive approach to the study through questioning and discussion. The team provided both insider and outsider perspectives on this study, to expose biases while using their individual strengths.

## Findings

579 (86.5%) MGP midwives, 68 (10.2%) MGP managers and 22 (3.3%) executive managers of MGP services completed the questionnaire. For reporting strength, the responses from MGP managers and executive managers, were combined to total 90 (13.5%). Participants here refers to everyone who participated.

### *The best and worst aspects about MGP*

According to the participants, the best aspects about MGP included the midwives, the model, as well as the women and families (see Table 2). The worst aspects included the culture beyond the MGP, the culture within the MGP, service management, and the effects on health and lifestyle (see Table 3). These are discussed in turn.

### *The midwives*

Some participant comments (n=57, 5.6%) noted that their colleagues and the relationship within the group practice was the best aspect about working in an MGP. Working in a cohesive group with people they admired and who held similar philosophies, offered a sense of belonging. Some participants (n=15, 1.4%) spoke favourably about the reciprocal mentoring and support they and other midwives received when they started in MGP. They explained that midwives have steep learning curves when they first start in MGP and described the pleasure in watching the growth:

> I deeply appreciate working alongside my team members who care passionately about midwifery and the birthing rites of the families we provide care for (*midwife, ID301*).

> I love managing an amazing group of passionate and motivated midwives (*manager, ID401*).

**Table 2**
The best aspects about MGP.

| Main Category | Subcategory | Quotes (n) | Percentage |
|---|---|---|---|
| ***The Midwives*** | | ***72*** | ***7.1*** |
| | Mentoring, support, and development of midwives | 15 | 1.4 |
| | The midwives that work in MGP | 57 | 5.6 |
| ***The Model*** | | ***335*** | ***33.0*** |
| | Autonomy | 91 | 8.9 |
| | Flexibility and using all my skills | 163 | 16.0 |
| | Job satisfaction | 81 | 7.9 |
| ***The Women and Families*** | | ***606*** | ***59.8*** |
| | Providing woman centred continuity of care | 309 | 30.5 |
| | The relationships with women and families | 297 | 29.3 |

**Table 3**
The worst aspects about MGP.

| Main Category | Subcategory | Quotes (n) | Percentage |
|---|---|---|---|
| ***Culture Beyond the MGP*** | | ***211*** | ***25.1*** |
| | Fighting to reduce medical interference | 49 | 5.8 |
| | Limited support, bullying, poor culture | 107 | 12.7 |
| | Limited understanding, appreciation, and respect | 55 | 6.5 |
| ***Culture Within the Group*** | | ***89*** | ***10.6*** |
| | Limited cohesion, reciprocity, and contact | 70 | 8.3 |
| | Managing the group issues | 19 | 2.2 |
| ***Service Management*** | | ***169*** | ***20.1*** |
| | Limited support and value from management | 89 | 10.6 |
| | Staff shortages, expecting too much, limited resources and poor service planning | 80 | 9.5 |
| ***Effects on Self and Lifestyle*** | | ***370*** | ***44.1*** |
| | Poor work life/family life balance, burnout, tired | 215 | 25.6 |
| | On-call, the telephone and pay not reflecting the work | 155 | 18.4 |

### *Culture within the group*

Approximately 10.6% of participant comments said the culture within the MGP was the worst aspect about MGP (see Table 2). They referred to limited cohesion, reciprocity, and contact (n=70, 8.3%). Some said they did not get on well with each other, had limited access to support, held different philosophies, and worked differently. They also said the limited contact with each other, especially face-to-face, made them feel isolated and too independent:

> Didn't trust my team members to adequately care for my women, so had no time off (*midwife, ID341*).

> Feeling lonely, like an outsider. Always having to be the bigger person (*midwife, ID346*).

Participants also referred to the need to manage group issues (n=19, 2%). They reported that dealing with problems within the group were the worst aspects about MGP. These included conflict, demanding midwives, poor philosophies, over-servicing, and weak boundaries of care.

> Dynamics that are detrimental to cohesive teamwork (*manager, ID533*).

> Managing midwives who are 'midwife centric' not 'woman centred' (*manager, ID213*).

*The model*

The model was described as one of the best aspects of MGP (n=335, 33.0%). Specifically, participant comments referred to: Flexibility and using all my skills (n=163, 16.0%); autonomy (n=91, 8.9%); and job satisfaction (n=81, 7.9%). For some, the MGP provided a way that they could use all their skills working across the continuum of maternity care, and to their full scope of practice. Although midwives could not control when they were called in for urgent issues, some said having flexibility over scheduled work was better for their family life (see Table 2):

> Working at the fullest of my scope is amazing (*midwife, ID107*).

> I can spend more time with my family working in the MGP model (*midwife, ID32*).

Having autonomy meant that MGP midwives could manage their own hours and workload. This enabled them to prioritise and plan the care they delivered, which they described as being individualised and holistic. Job satisfaction from seeing the impact of their care gave some a sense of fulfillment:

> The autonomy, allowing me to do my best (*midwife, ID252*).

> Feeling as though you are making a difference (*midwife, ID93*).

*Culture beyond the MGP*

One-quarter (n=211, 25.1%) of the participant comments said the culture beyond the MGP was the worst aspect about working in an MGP model (see Table 3). They spoke of fighting to reduce medical interference (n=49, 5.8%), limited support, bullying, and poor culture (n=107, 12.7%); and limited understanding, appreciation, and respect (n=55, 6.5%). Feeling as if they had to constantly stand up for a woman's right to her autonomy was exhausting for midwives. Knowing they were not supported by core services meant they felt their care would be judged by people who might hold different values.

> It can sometimes be seen as a direct reflection on me as a practitioner if a woman uses her right to make an informed decision. Phrases like 'I thought you were better than that' or 'I personally wouldn't stake my registration on that', can be tiresome (*midwife, ID109*).

> Constant scrutiny and criticism from those who don't understand the model of care (*manager, ID151*).

Participants also said staff members affiliated with core services poorly understood the model and how they worked, resulting in limited support and respect. They reported feeling judged as being lazy because a large part of their work was in the community, not directly visible to hospital staff. They voiced how they were restricted by working within a hospital instead of in the community:

> The lack of understanding and compassion shown by core services at times of extreme acuity in MGP (*midwife, ID62*).

> Having ideas for how our care provision could significantly improve, but not being heard or being met with 'red tape' (*midwife, ID525*).

*Service management*

Concerns regarding how the service was managed accounted for 20.1% of what participants considered to be the worst aspect about MGP (n=169, see Table 3). They noted limited managerial support and value (n=89, 10.5%), particularly from executive managers, as well as being micromanaged:

> The worst thing for me was the lack of support from executive management, which ultimately led to my resignation (*manager, ID57*).

> Being micromanaged, not being involved in changes made within MGP. (*midwife, ID259*).

Furthermore, participant comments (n=80, 9.5%) reported that too much was expected of them, given limited resources (e.g., staff, workspaces, and tools), and poor service planning. Likert-scale questions revealed that very few midwives (n = 33, 5.7%) and managers (n = 12, 13.3%) always had the resources needed to do the job (see Table 5). Some reported being asked to take extra women when MGP colleagues had left, and to cover core service shortages, especially without extra pay:

> Being called upon to fill shortages in other areas due to lack of strategic planning (*midwife, ID206*).

> Having to fight for room to do appointments. Having to buy your own equipment (*midwife, ID355*).

*Effects on health and lifestyle*

The effects on midwife health and lifestyle accounted for 44.1% (n=370) of what participants described as the worst aspect about MGP (see Table 3). They spoke of concerns about the imbalance between personal and professional commitments, burnout, and tiredness (n=215, 25.6%). Midwives explained that the unpredictability of their hours, workload and lifestyle had considerable effects. They often missed family events and had insufficient sleep:

> I'm always tired and don't have time for my family as I always have to be available for my women (*midwife, ID209*).

> Fatigue and having to take up the slack to your own detriment, but not feeling like you can ask for help because everyone is overworked and burnt out (*midwife, ID183*).

Participants also spoke unfavourably about being on-call, the telephone, and poor pay (n=155, 18.4%). This was worsened by receiving calls out of office hours for non-midwifery and non-urgent issues. However, being on-call for extended times and frequently covering colleagues' calls had a considerable impact on their personal life:

> Random calls in the middle of the night and not related to labour, birth or an emergency (*midwife, ID16*).

> Feeling like you're always working. Holding all the phones too often (*midwife, ID125*).

*Women and families*

Over half of the comments from the participants (n= 606, 59.8%) reported that the women and their families were the best aspects about MGP (see Table 2). They referred to the importance of woman-centred continuity of care (n=309, 30.5%) to ensure women had choices and control over her healthcare and wellbeing. They also highlighted the importance of building trusting relationships with women and their families (n=297, 29.3%). This offered joy and opportunities to continue the relationships during subsequent pregnancies:

> The continuity of care and relationships we build allows me to be 'with woman' (*midwife, ID199*).

> Developing relationships that can last many pregnancies (*midwife, ID51*).

*MGP sustainability*

According to the participants, MGP sustainability could be bolstered by: an ability to provide woman-centred care; group arrangements and culture; manager support; and support and understanding from core and

medical services (see Table 4). Each is addressed in turn.

*Woman-centred care*

Participants indicated the importance of providing woman-centred care ($n$ = 181, 19.6%). They noted that for MGP to be sustainable, midwives had to build relationships with women and provide continuity of care ($n$ = 115, 12.5%). They also reported the importance of offering MGP to all women regardless of their obstetric or social complexity, to ensure equity. They suggested more funding was required to provide more MGPs and less core staff:

> Funding to allow midwives to provide adequate care to all women (*midwife, ID380*).

> More support from the hospital medical teams in supporting women's choices. I feel like there is still pressure on MGP to convince women to comply to hospital practice (*midwife, ID3*).

Participants also highlighted the role of consumer consultation and feedback (n=66, 7.1%). This would help to tailor the service to meet the women's needs. However, some participants were dissuaded from obtaining consumer feedback (see Table 4).

> We have been directed to discourage our women from providing feedback to the hospital (*midwife, ID17*).

> Currently have recruited two consumer representatives and hope to foster high level of consumer input (*manager, ID72*).

Likert-scale questions revealed that few midwives (n=27, 5%) and managers (n=18, 21.4%) indicated that consumers were always involved in MGP service planning. This suggests that consumer input was not always deemed essential. According to over half of the managers (n=55, 65.5%), consumers were always encouraged to contribute feedback regarding the MGP service – however, less than one-third of midwives (n=154, 29.3%) indicated this (see Table 5).

*Group arrangements and culture*

A small proportion of participant comments (n=80, 8.6%) advised that group arrangements and culture were essential for MGP sustainability (see Table 4). Group arrangements pertained to solidarity as demonstrated by the group work arrangements and similar philosophies (n=49, 5.3%). Some said it was important to have a sense of reciprocity within the group. Others described how easy it was to avoid helping group members, especially when they were tired:

> Having a team where every member contributes and supports each other. It is hard because I think it's natural to want to be selfish with your own time on MGP because it is so precious, but I think MGP

**Table 4**
What would make MGP more sustainable.

| Main Category | Subcategory | Quotes (n) | Percentage |
|---|---|---|---|
| ***Woman Centred Care*** | | ***181*** | ***19.6*** |
| | Continuity, relationships & woman-centred care | 115 | 12.5 |
| | Consumer satisfaction and input | 66 | 7.1 |
| ***Group Arrangements and Culture*** | | ***80*** | ***8.6*** |
| | Cohesion, similar philosophies and how it works | 49 | 5.3 |
| | Pay | 31 | 3.3 |
| ***Manager Support*** | | ***493*** | ***53.5*** |
| | Adequate staffing, new graduates, students, orientation | 265 | 28.8 |
| | Support from management at all levels | 228 | 24.7 |
| ***Support and Understanding from Core and Medical Services*** | | ***166*** | ***18.0*** |

**Table 5**
Likert question results. Participants were asked to respond to the following statements.

| Role | Not at all n (%) | Not usually n (%) | Unsure n (%) | Sometimes n (%) | Most of the time n (%) | All of the time n (%) |
|---|---|---|---|---|---|---|
| **MGP midwives are adequately renumerated for the care they provide** | | | | | | |
| Midwives n=579 | 52 (9.0) | 106 (18.3) | 33(5.7) | 128(22.1) | 204 (35.2) | 56 (9.7) |
| Managers n=90 | 2(2.2) | 8(8.9) | 0(0.0) | 9(10.0) | 35 (38.9) | 36 (40.0) |
| **Student midwives have the opportunity to work in our MGP** | | | | | | |
| Midwives n=566 | 32 (5.7) | 24(4.2) | 7(1.2) | 125(22.1) | 141 (24.9) | 237 (41.9) |
| Managers n=89 | 6(6.7) | 5(5.6) | 0(0.0) | 18(20.2) | 15 (16.9) | 45 (50.6) |
| **New graduate midwives are supported and mentored in our MGP** | | | | | | |
| Midwives n=566 | 127 (22.4) | 78 (13.8) | 23(4.1) | 108(19.1) | 138 (24.4) | 92 (16.3) |
| Managers n=89 | 7(7.9) | 7(7.9) | 0(0.0) | 21(23.6) | 20 (22.5) | 34 (38.2) |
| **Midwives (with experience) starting in our MGP are mentored and supported** | | | | | | |
| Midwives n=566 | 13 (2.3) | 63 (11.1) | 15(2.7) | 156(27.6) | 205 (36.2) | 114 (20.1) |
| Managers n=89 | 3(3.4) | 2(2.2) | 0(0.0) | 13(14.6) | 39 (43.8) | 32 (36.0) |
| **Managers of the service have time for the MGP when needed** | | | | | | |
| Midwives n=536 | 24 (4.5) | 79 (14.7) | 33(6.2) | 178(33.2) | 177 (33.0) | 45 (8.4) |
| Managers n=85 | 0(0.0) | 13 (15.3) | 2(2.4) | 13(15.3) | 38 (44.7) | 19 (22.4) |
| **MGP midwives feel supported by their manager** | | | | | | |
| Midwives n=536 | 24 (4.5) | 65 (12.1) | 13(2.4) | 164(30.6) | 187 (34.9) | 83 (15.5) |
| Managers n=85 | 3(3.5) | 3(3.5) | 5(5.9) | 13(15.3) | 50 (58.8) | 11 (12.9) |
| **Managers typically resolve tension in the workplace** | | | | | | |
| Midwives n=536 | 53 (9.9) | 137 (25.6) | 43(8.0) | 199(37.1) | 91 (17.0) | 13 (2.4) |
| Managers n=85 | 3(3.5) | 7(8.2) | 4(4.7) | 18(21.2) | 42 (49.4) | 11 (12.9) |
| **Nursing executives understand midwifery models of care** | | | | | | |
| Midwives n=536 | 84 (15.7) | 154 (28.7) | 68 (12.7) | 136(25.4) | 74 (13.8) | 20 (3.7) |
| Managers n=85 | 13 (15.3) | 24 (28.2) | 3(3.5) | 25(29.4) | 13 (15.3) | 7(8.2) |
| **Getting on well with each other is important to sustain the model** | | | | | | |
| Midwives n=579 | 0(0.0) | 0(0.0) | 3(0.5) | 4(0.7) | 210 (36.3) | 362 (62.5) |
| Managers n=90 | 0(0.0) | 0(0.0) | 1(1.1) | 1(1.1) | 36 (40.0) | 52 (57.8) |
| **The midwives working in MGP get on well with each other** | | | | | | |
| Midwives n=579 | 2(0.3) | 13(2.2) | 2(0.3) | 76(13.1) | 411 (71.0) | 75 (13.0) |
| Managers n=90 | 0(0.0) | 4(4.4) | 2(2.2) | 13(14.4) | 66 (73.3) | 5(5.6) |
| **Midwives in MGP have the resources they need to do the job required of them** | | | | | | |
| Midwives n=579 | 9(1.6) | 68 (11.7) | 7(1.2) | 179(30.9) | 283 (48.9) | 33 (5.7) |
| Managers n=90 | 0(0.0) | 10 (11.1) | 1(1.1) | 20(22.2) | 47 (52.2) | 12 (13.3) |
| **Consumers are actively encouraged to contribute feedback regarding the MGP service** | | | | | | |
| Midwives n=525 | 27 (5.1) | 44(8.4) | 17(3.2) | 124(23.6) | 159 (30.3) | 154 (29.3) |
| Managers n=84 | 1(1.2) | 5(6.0) | 0(0.0) | 8(9.5) | 15 (17.9) | 55 (65.5) |
| **Consumers have been involved in every aspect of the MGP service planning** | | | | | | |
| Midwives n=525 | 52 (9.9) | 90 (17.1) | 173 (33.0) | 107(20.4) | 76 (14.5) | 27 (5.1) |
| Managers n=84 | 2(2.4) | 11 (13.1) | 11 (13.1) | 16(19.0) | 26 (31.0) | 18 (21.4) |

As the denominators change – the percentage is reported as being correct for the percentage on that line

works best when everyone is willing to put their hand up and support each other (*midwife, ID599*).

MGP midwives described the need to trust and support each other. In the Likert-scale responses, over half of the managers (n=52, 57.8%) and midwives (n=362, 62.5%) indicated that MGP sustainability required team members to always work well together. Yet few managers (n=5, 5.6%) and midwives (n=75, 13%) advised that MGP midwives always worked well together (see Table 5).

How the group worked and the arrangements around on-call, leave, caseload numbers and the choices women had, were also deemed as important to sustainability. Some said how the service operated and who they work with should be determined by the midwives who worked in it. However, there were different opinions on how the service should operate – some midwives wanted to be on-call for the women in their caseload; others wanted to work shifts in a team or share the on-call. Documenting group expectations optimised the likelihood that members had a shared understanding:

Options for team midwifery as well as caseload (*midwife, ID417)*

More staff, less on call (*midwife, ID401)*

Having developed a 'working directive to guide our practice including our philosophy and goals has been invaluable (*manager, ID350*).

Some participants (n=31, 3.3%) suggested that MGP sustainability might be bolstered by better pay conditions, given the on-call, responsibility, and hours worked. Remuneration rates vary across Australia, between and within states [28]. Furthermore, relatively few managers (n=36, 40%) and midwives (n=56, 9.7%) indicated that midwives were always renumerated for the care they provided:

Remuneration equivalent to experience, years of work, on-call time, commitment and for teaching doctors' normality (*midwife, ID460*).

### *Manager support*

Approximately half of the participant comments (n=493, 53.5%) said that managerial support was important to sustain MGP (see Table 4). This encompassed adequate staffing, including support for new graduates, and students, (n=265, 28.8%). Appropriate orientation and mentorship would enable new staff to have favourable experiences with MGP. Adequate staffing and working conditions were seen to ensure continuity and prevent staff burnout:

Graduate midwives are the future and the key to succession planning in our team of ageing midwives. However, management refuse to allow them to do MGP (*midwife, ID155*).

Staffing has been a constant issue and long-term sick leave not being replaced is a constant source of extra workload for MGP (*midwife, ID45*).

In the Likert-scale responses, managers and midwives held different views on whether MGP clinicians were mentored and supported. For instance, while over one-third of the managers (n=32, 36%) noted that experienced midwives were always supported and mentored when commencing in MGP, approximately twenty percent of the midwives (n=114, 20.1%) indicated this. Similarly, while over one-third of the managers (n=34, 38%) noted that new graduate midwives were always supported and mentored, very few midwives (n=92, 16.3%) indicated this. Furthermore, some managers (n=11, 12.3%) and midwives (n=56, 9.9%) indicated that student midwives seldom had the opportunity to work in an MGP (see Table 5).

Almost one-quarter of participants (n=228, 24.7%) said that support at all levels of management was vital for sustainability, particularly that of executive managers. This was partly because of the tension and stress that MGP managers experienced from executive and core service managers.

Our direct manager is incredibly supportive and works well beyond the call of duty to be available to her MGP midwives. Our manager is not at all well supported by the remaining management team (*midwife, ID51*).

Our MGP manager is also the Birth Unit Midwifery Unit Manager, we are not prioritised at all. No sick leave or annual leave or maternity leave cover. Our manager doesn't come to meetings unless asked (*midwife, ID167*).

Likert-scale responses showed that managers (n=57, 67%) and midwives (n=222, 41.4%) indicated that the MGP service manager typically had time for the MGP when needed. However, relatively few managers (n=20, 23.5%) and midwives (n=94, 17.5%) noted that nursing executives understood midwifery models of care all or most of the time (see Table 5).

Participants were asked whether MGP managers should have previous experience working in an MGP. Most participants (n=67, 79.5%) reported that the manager needed MGP experience to understand the model and the impact on midwives. While fewer (n=120, 20%) said it was not essential, they did recognise the importance of a comprehensive understanding of the model, excellent management skills, and a woman-centred philosophy. They were also asked to rank the characteristics that are most important in an MGP manager. According to the participants, MGP managers required the ability to: care about and fully understand woman-centred care; and trust and carefully manage the midwives without micromanaging them (see Table 6). Conversely, being 'firm but fair' or 'efficient and meeting key performance indicators' were deemed least important.

### *Support and understanding from core and medical services*

Participants (n=166, 18%) recognised the importance of support from both medical and core services to sustain the MGP (see Table 4). They reported this would require an understanding of the model and benefits. Because much MGP work is offsite, they noted that core service staff presumed they were not working. The midwives also indicated that medical teams should trust MGP midwives and the women to make decisions based on what the women wanted and needed. The participants reported that it would be helpful if MGP midwives were seen as part of the team:

I find core struggle to understand how we work because they can't see a lot of the work we do (*midwife, ID133*).

More understanding and trusting medical staff, to support the women and their choices (*midwife, ID504*).

**Table 6**
MGP manager characteristics. Rank the characteristics you find most important in an MGP manager 1–6 (6 is least important).

| Characteristics | N | Mean | Std. Deviation |
|---|---|---|---|
| They care about and fully understand woman-centred care and MGP | 619 | 1.47 | .944 |
| They trust midwives and carefully manage them without micromanaging them | 619 | 2.80 | 1.61 |
| They are nurturing and easy to talk to | 619 | 3.45 | 1.309 |
| They trust the midwives and leave them to self-manage the practice | 619 | 4.02 | 1.495 |
| They are firm but fair | 619 | 4.25 | 1.274 |
| They are efficient and meet their key performance indicators | 619 | 5.01 | 1.213 |

## Discussion

This study explored the conditions that help to optimise the management of MGP in Australia from the perspectives of 579 MGP midwives and 90 managers of MGP services. Although understandings of midwifery-led continuity of care models have increased in the past twenty years [29–32], there remains a disconnect between the evidence and the implementation.

One of the primary studies on burnout in midwifery-led continuity of care models provided the grounding principles for MGP. These included: occupational autonomy; developing meaningful relationships with women; and social support [33]. Our study has shown that these principles, still hold true for ensuring MGP services work, however, there may be other contemporary influences on sustainability that also require consideration.

### *What works well?*

Forming meaningful relationships with women and their families, along with providing woman-centred continuity of care continues to be the biggest source of satisfaction for midwives. Developing a trusting, meaningful, relationship throughout the maternity continuum is beneficial for midwives and women [34]. In this study, the midwives described that being 'with woman' made them feel responsible for the protection of the woman's options and bodily autonomy, and that they would fight for those rights.

While most participants described actively seeking input and feedback from women, some said that hospital managers deterred them from doing so. A well-implemented, woman-centred service involves all stakeholders, including the midwives and the women [9]. Involving the midwives means they have ownership of the service and control over how they work [35]. Keeping women involved in planning keeps the focus of the service providers on the needs of the women [9]. Partnering with consumers so that they are involved, to the extent that they choose in their own care, is one of the standards of care that underpins all other standards of care in Australia [36].

In this study, autonomy was deemed as a valuable component of working in MGP. Reflecting extant research [33], midwives valued the ability to organise their own workdays and spend as much time with women as they needed, to provide the best care. Some midwives commented on how flexible work conditions worked for their families, whereby they could spend more time with them. This has been reflected in other studies [34].

Working well with the other group members was a source of joy for those midwives who worked in a cohesive group. This gave them a sense of camaraderie, especially when they perceived that the rest of the hospital did not hold the same midwifery values. The managers also described the pride in managing midwives with such passion for women and midwifery values. These relationships can affect how midwives feel about going to work and how they provide woman-centred care [37]. A group with a sense of reciprocity and a shared philosophy can offer satisfaction and is equally as important to sustainability as the relationship with women [17,37].

### *What does not work well?*

Although midwives valued forming meaningful relationships with women, many did not like being on-call. This might account for the recent expansion of midwifery antenatal, postnatal (MAP) models, despite limited evidence for their effectiveness. MAP models focus on providing antenatal and postnatal continuity, while any planned or unplanned inpatient care, for women in this model, is provided by midwives working in the hospital providing standard care [38]. Being on-call for other midwives for extended periods was also a source of displeasure. Although being on-call for each other is necessary for leave arrangements, some participants indicated they shared being on-call. Sharing being on-call would reduce their on-call hours, but increase their likelihood of being called in, especially for women they do not know. Being on-call for part-time midwives, instead of part-time midwives working in job share situations, might also cause frustration.

Some midwives indicated that being on-call for less than 12 hours or working in a team model would be better for their work-life balance. Some services were described by participants as team midwifery services rather than MGPs. Providing a team midwifery model, alongside an MGP might allow more midwives to work in continuity models. However, models that provide care by a team of midwives should be called 'team midwifery' and adhere to the principles for this model [2]. It is imperative that MGP models are correctly identified and defined for: accurate evaluation of the outcomes; midwives who want to provide MGP care; and the women who expect MGP care [2,33,39].

Participants described work-life imbalance as the worst aspect about MGP. This warrants consideration since all midwives are vulnerable to burnout [40]. A recent Australian study found that 44% of MGP midwives were under 40 years of age and half had less than 10 years' experience [19], making them vulnerable to burnout [41]. Other circumstances that might increase MGP midwives vulnerability to burnout are: strong emotional connections to families, particularly when outcomes are unanticipated [42]; tiredness [41]; and increasing complexities that require more care [19]. Therefore, a culture of self-care should be an integral part of MGP, along with a commitment from service providers to ensure that the midwives wellbeing is supported [18]. Self-care might involve a culture that supports and encourages principles like: meditation; yoga; slowing down; self-compassion and compassion for each other [43].

This study found that short staffed MGPs prevents midwives from asking their MGP colleagues for help, and not take sick leave. They also reported taking women from other midwives' caseloads when short staffing resulted in staff attrition. Staff shortages also affected their ability to gain assistance from core midwives when required and strained the relationship between core and MGP midwives. MGP midwives work closely with their core midwifery colleagues and rely on them for support. Organisational factors, such as excessive workloads, low staffing and poor workplace culture, contribute to midwives' susceptibility to burnout [40].

Some MGP midwives described being expected to work for core services when staffing was low. MGP work is dynamic; sometimes it is calm, while other times it is hectic. Being able to rest when it is quiet is at the heart of self-care, which helps midwives cope with the busy times [17].

Staffing could be helped by investing in new graduate midwives. Newly graduated midwives show high levels of job satisfaction in MGP, bolstering workforce capacity [44]. Studies recognise the need for new graduates to be mentored, have a longer orientation, and a lighter caseload [44]. Support and mentorship for new graduate midwives and new (experienced) midwives were inconsistent across the survey. However, appropriate mentorship and orientation might attract new staff [17].

Prioritising Bachelor of Midwifery (BMid) programs in all Australian states, might also improve MGP staffing given that MGP services have almost twice the national average of BMid educated midwives [19]. A few participants in this study reported that students were unable to work in their MGP service. Workforce readiness and staffing might be improved if all students have the opportunity to experience MGP [45].

Despite manager's feeling midwives were financially compensated for the responsibility, experience, and on-call involved, MGP midwives did not. This reflects previous research that also described midwives feeling that they were not financially compensated for the care they provided [46]. Furthermore, there are different pay agreements throughout Australia [28], with some states offering much less than others, seeding discontent. It might be pertinent for a national approach and pay agreements that help to attract and retain midwives.

One of the grounding principles for MGP is support at home and

work [33,39]. While some midwives said the support within the group was exceptional, others spoke of a very unsupportive environment. Limited cohesiveness and reciprocity, makes being an MGP midwife more difficult [37]. Midwives rely on their colleagues to manage telephone calls during leave periods, knowing the women in their caseload will be cared for [17]. Cohesion can be enhanced by, social activities, and attending regular meetings, enhancing a sense of belonging and perceived value [47]. It is also important for each group member to be aware of the group expectations, as well as having regular and equal time off from being on-call [37].

Limited support from core managers and medical staff can compromise organisational culture, the care of women and MGP sustainability [40,47]. Support by core services should be embedded in the way the model was implemented and how it is operationalised [18]. Unfortunately, there is still tension between the holistic model of MGP and the paternalistic medical model [17]. This tension might explain why some midwives in this study reported a need to fight for a woman's right to her bodily autonomy.

Support from the direct manager is essential for sustainability [18]. Although most participants reported having adequate support from their MGP manager, some reported being micromanaged. Most managerial concerns were directed at executive managers who were said to expect too much, and provide limited resources, including staff. Participants reported limited understanding and value of MGP from the executive management, which might be a reflection of the dominance of nurses in these positions [48].

### *Strengths and limitations*

Around half the number of the practising MGP midwives in Australia responded to this survey, thus it may not reflect the views of all MGP midwives and managers. The questions were directed towards MGP management and might have directed the participants focus. These findings reflect Australian views and therefore might not be useful, internationally. Responses may also have been shaped by the COVID-19 pandemic when this survey took place, when many services were disrupted.

### *Recommendations*

There are notable inferences for midwives, managers, scholars, and policymakers from this study. For midwives, finding a model that suits your circumstances is important. A team model might be an option for midwives who find on-call difficult; similarly, a job share MGP position might also be appropriate. For managers, consider the employment of new graduate midwives in MGP, and ensure student midwives have experience in the model. It might be beneficial to establish models of care that are true to their name and resist morphing MGP into a team midwifery program. Instead, consider establishing continuity models (e.g., team midwifery) alongside MGP that provide midwives with options that meet their personal situations. Staff retention might be improved with suitable orientation and mentorship, along with a lighter initial caseload and a healthy culture.

Executive managers should support the MGP manager and service. It might be advantageous to ensure that midwifery services are managed by midwives at all levels of management. For scholars, research is required to determine the individual attributes that encourage longevity in MGP midwives. It might be of use to co-design continuity of care models with midwives and consumers. Research into the core services and executive managers on their opinions on how to improve MGP sustainability, would also be helpful. For policymakers, the sustainability of MGP requires good initial planning and ongoing support from all stakeholders. Midwives should be paid adequately for being on-call and a national approach should be considered.

## Conclusions

The provision of woman-centred care and the relationship between a midwife and woman remain the main motivators for midwives to work in MGP. However, work-life imbalance is a deterrent requiring urgent attention. Although, being on-call, feeling tired, and working long hours, contributed to work-life imbalance, staff shortages exacerbated this. Staff shortages might be addressed by adequate orientation and support of new midwives and by improving workforce readiness of students and new graduates. A culture of support and Improved renumeration might also assist with retention and recruitment of staff. A culture of self-care might help improve work-life balance for both MGP managers and midwives.

## Ethical statement

Ethical approval of the study was granted by Western Sydney University Human Research Ethics Committee, HREC Approval Number H13428, 10th September 2019. The study was undertaken according to research ethics guidelines, participation was voluntary, and informed consent was obtained from all participants.

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## CRediT authorship contribution statement

**Leonie Hewitt:** Conceptualisation, Formal analysis, Data Curation, Investigation, Writing – Original draft **Ann Dadich:** Supervision, Writing – Review and Editing, Validation **Donna Hartz:** Supervision, Writing – Review and Editing, Validation **Hannah Dahlen:** Supervision, Writing – Review and Editing, Validation, Project administration.

## Declaration of Competing Interest

None declared.

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